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Health, Allergy & Medication Questionnaire

Your answers to the following questions will help us provide your prescription drug benefit services including, for example, filling your prescriptions and alerting your doctor about possible medication problems. To best serve you, we need to know what prescription and nonprescription medications you are currently taking. We also need to know if you have any known allergies, conditions or diseases.

Please complete this questionnaire only for the person whose name is pre-printed in Section 1.

- If your health, allergy and/or medications information does not fit on the form you can provide additional information on plain paper and attach to this form.
- If you need additional forms, you may call your toll-free Customer Service number located on the back of your ID card.

envelope provided.	ed wedco by wan order form in the
Section 1: This form is provided exclusively form the Name: JAMES3 BOND3 Month/Year of Birth: 01/1931 Gender:	
Section 2: Prescription Medications.* Please list the *Information can be found on the prescription labels	he current prescription medications you are taking. s. If none, please check here. [] NONE
Prescription Medication	Prescription Medication
Please attach names of additional prescription m	edications if there is not enough room on this page.
Section 3: Nonprescription Medications. Please li regular basis that do not require a prescription from a	st all nonprescription medications you take on a doctor. Such as: aspirin, ibuprofen, <i>Advil</i> ®, <i>Motrin</i> ®. If none, please check here. [] NONE
Nonprescription Medication	Nonprescription Medication

Please continue on the other side to tell us about any health, allergy or medical conditions.

Please attach names of additional nonprescription medications if there is not enough room on this page.









Section 4: Drug Allergy Conditions. Please fill in the circle ONLY if you have had an allergy or bad reaction to this medication in the past. If you have had an allergy to a medication not listed below, please print the name of that medication in the blank spaces at the bottom of this section.

Penicillins/cephalosporins	Such as <i>Amoxil</i> ®, amoxicillin, ampicillin, <i>Ceclor</i> ®, <i>Ceftin</i> ®, <i>Keflex</i> ®, cephalexin	0
Tetracycline antibiotics		0
Erythromycin, Biaxin®, Zithromax®		0
Codeine	Such as Robitussin AC®, Tylenol #3®	0
Non-steroidal anti-inflammatory drugs (NSAIDs)	Such as ibuprofen, Advil®, Motrin®	0
Aspirin (salicylates)		0
Sulfa drugs	Such as Septra®, Bactrim®, TMP/SMX	0
Iodine		0
If there is an allergy to a medication that is not listed medication in the space below. Example: <i>morphine</i>	l above, please print the name of that	

Section 5: Medical Conditions. Please fill in a circle **ONLY** if a doctor ever said that you have had any of the following conditions.

Heart failure (weak heart)	0	Gastric reflux, heartburn or esophagitis (GERD)	0
High blood pressure (hypertension)	0	Inflammatory bowel disease (colitis, Crohn's disease)	0
Heart attack or angina	0	High pressure in the eyes (glaucoma)	0
High cholesterol (hypercholesterolemia)	0	Seizures	0
Stroke	0	Poor circulation in the legs (peripheral vascular disease)	0
Chronic bronchitis or emphysema (COPD)	0	Trouble with blood not clotting properly	0
Asthma	0	Enlarged prostate (benign prostatic hyperplasia, BPH)	0
Allergies, runny nose, hay fever (allergic rhinitis)	0	Arthritis	0
High blood sugar (diabetes)	0	Osteoporosis	0
Thyroid disease	0	Depression	0
Peptic, stomach or duodenal ulcer	0	Migraine headaches	0
Print other medical conditions not listed above	in t	he space below. Example: glaucoma	

Please return the questionnaire along with the completed Medco By Mail order form in the envelope provided.

Did you complete both sides?

Thank you very much.





